ReliaStar Life Insurance Company
Insurance Information Practices Notice

We are pleased to provide you with information regarding this Evidence Form. This information is provided to you in accordance with legislation enacted in your state.

Our Underwriting Procedures

For certain types of coverage, we require proof of good health to determine if you are eligible for the coverage you requested. We review all of the information in the Evidence Form, and, if necessary, confirm or add to this information in the ways described in this notice.

Privacy and Information Practices

Collecting Information

Your Evidence Form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will
  be given to you for your records.
- Obtain information from the Medical Information Bureau (MIB). See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request called an Amendment.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with ReliaStar Life or its affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage. Medical information, however, will only be disclosed through the attending licensed physician.

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc. (Medical Information Bureau)

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112. MIB's phone number
is (617) 426-3660. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Public Employees Benefits Board

Life Insurance Evidence of Insurability Form

- Type or print clearly in ink.
- Return to agency or ReliaStar Life Insurance Co.

SECTION 1:

Social Security Number	Last Name	First Name	Middle Initial	Agency/Division

House Number	Street Address	Apt./Unit Number	Phone: Work / Home	Birth Date (MO/DAY/YR)	☐ Male ☐ Female

City	State	ZIP Code + 4	Do you or your spouse/domestic partner smoke? ☐ Yes ☐ No If no, complete and sign Nonsmoker Certification section.

SECTION 2: EMPLOYEE: Evidence of insurability

(To be completed only when applying for Part C or Part D more than 60 days after original insurance eligibility date, OR when applying for more than $50,000 Part D within 60 days of original eligibility date.)

Employee _____ Height _____ Weight _____ Sex _____

Occupation _____ Birth Date _____ Birthplace _____ Marriage/Domestic Partnership Date _____

Provide details for any "Yes" answers below. Use a separate sheet if necessary.

1. Have you had any injury, sickness, or ailment, or have you consulted or been treated by a health care provider for any reason in the past five years? ☐ Yes ☐ No
2. Have you ever had:
   - A. High Blood Pressure, Heart Disease, or Arteriosclerosis? ☐ Yes ☐ No
   - B. Mental Illness, Stroke, or Epilepsy? ☐ Yes ☐ No
   - C. Cancer, Diabetes, or Nephritis? ☐ Yes ☐ No
   - D. Any problems with the back or spine? ☐ Yes ☐ No
   - E. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an immune system disorder? ☐ Yes ☐ No
3. Are you now unable to work full time because of any disease or disorder? ☐ Yes ☐ No
4. Do you take regular medication for treatment or control of any condition or ailment? ☐ Yes ☐ No
5. Do you contemplate any operation or visit to a doctor for an existing injury or ailment? ☐ Yes ☐ No

Injuries, Diseases, Disorders, and Operations	Month, Year	Duration	Result	Names and Addresses of Health Care Providers Consulted

SECTION 3: SPOUSE/DOMESTIC PARTNER: Evidence of insurability

(To be completed only when applying for Part B Basic or Part B Supplemental Spouse Life more than 60 days after original insurance eligibility date, OR when applying for more than $25,000 Part B Supplemental Spouse Life within 60 days of original insurance eligibility date.)

NOTE: The employee will always be designated as beneficiary for spouse/domestic partner and dependent life insurance.

Are you a state employee? ☐ Yes ☐ No
If yes, are you also applying for coverage through your agency? ☐ Yes ☐ No

Spouse/Domestic Partner _____ Height _____ Weight _____ Sex _____

Occupation _____ Birth Date _____ Birthplace _____ Marriage/Domestic Partnership Date _____

Provide details for any "Yes" answers below. Use a separate sheet if necessary.

1. Have you had any injury, sickness, or ailment, or have you consulted or been treated by a health care provider for any reason in the past five years? ☐ Yes ☐ No
2. Have you ever had:
   - A. High Blood Pressure, Heart Disease, or Arteriosclerosis? ☐ Yes ☐ No
   - B. Mental Illness, Stroke, or Epilepsy? ☐ Yes ☐ No
   - C. Cancer, Diabetes, or Nephritis? ☐ Yes ☐ No
   - D. Any problems with the back or spine? ☐ Yes ☐ No
   - E. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an immune system disorder? ☐ Yes ☐ No
3. Are you now unable to work full time because of any disease or disorder? ☐ Yes ☐ No
4. Do you take regular medication for treatment or control of any condition or ailment? ☐ Yes ☐ No
5. Do you contemplate any operation or visit to a doctor for an existing injury or ailment? ☐ Yes ☐ No

Injuries, Diseases, Disorders, and Operations	Month, Year	Duration	Result	Names and Addresses of Health Care Providers Consulted

Authorization and acknowledgment–Please read and sign below:

For underwriting and claims purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau (MIB), Inc., or employer to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery, or any non-medical information as they apply to me, my spouse/domestic partner, or any of my children who are to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations–42CFR Part 2. I may revoke this authorization as it applies to any information protected by this Federal Regulation at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB, Inc. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or in any way relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Insurance Information Practices Notice and Notice Regarding MIB, Inc. (on the back of the *Evidence of Insurability Form*).

Date	Employee's Signature *(required)* Please sign printed copy	
Date	Spouse/Domestic Partner's Signature *(if applying)* Please sign printed copy	Spouse/Domestic Partner's Social Security Number *(if applying)*

For Agency Use
Date sent to carrier: _____

Mail completed form to:
ReliaStar Life Insurance Co., P.O. Box 20, Route 7325, Minneapolis, MN 55440-0020

Agency Code	Subagency Code

Public Employees Benefits Board

Life Insurance Enrollment/Change Form

- Type or print clearly in ink.
- Shaded areas for agency use only.
- Return to your payroll or benefits office.

Note to agencies: Review for completeness and accuracy, and key guaranteed issues before submitting to ReliaStar Life Insurance Co.

SECTION 1: Sections 1-5 must be completed by employee.

Social Security Number	Last Name	First Name	Middle Initial	Agency/Division

House Number	Street Address	Apt./Unit Number	Phone: Work / Home	Birth Date (MO/DAY/YR)	☐ Male ☐ Female

City	State	ZIP Code + 4	Do you or your spouse/domestic partner smoke? ☐ Yes ☐ No If no, complete and sign Nonsmoker Certification section.	Annual Salary

Is this enrollment within the first 60 days of eligibility? ☐ Yes ☐ No Type of enrollment? ☐ New ☐ Change ☐ Transfer	Current Agency Hire Date	Original Insurance Eligibility Date

SECTION 2: Please fill in the coverage you desire in the unshaded column.

Type of Coverage			2A. Current Coverage Yes	2A. Current Coverage No	2A. Current Coverage Amount	2B. Desired Coverage Yes	2B. Desired Coverage No	2B. Desired Coverage Amount	Effective Date No Approval Required	Effective Date After Approval
Basic Life $25,000 and AD&D $5,000		Part A	X		$25,000 $5,000	X		$25,000 $5,000	Part A premium paid by employer except when on LWOP	
Basic Spouse Life	(Must enroll within 60 days of eligibility; otherwise may require approval.)*	Part B			$2,500	☐	☐	$2,500		
Basic Children Life	(Does not require approval.)*	Part B			$2,500	☐	☐	$2,500		
Supplemental Spouse Life	(Must be enrolled in Part B Basic. No approval needed for first $25,000 if within 60 days of eligibility. Cannot exceed 50% of employee's coverage.)*	Part B				☐	☐			
Optional Life (Must enroll within 60 days; otherwise approval required.) If enrolling for maximum allowed under Part C, do you want coverage to automatically increase to the maximum as your pay increases?* ☐ Yes ☐ No		Part C				☐	☐			
Supplemental Life	(No approval required for first $50,000 if within 60 days of eligibility. Additional amount always requires approval.)*	Part D				☐	☐			
Optional AD&D	(Does not require approval.)*	Part E	☐ W/O DEP ☐ WITH DEP			☐ W/O DEP ☐ WITH DEP				

*Date guaranteed issues keyed by agency payroll/insurance office: _____

SECTION 3: BENEFICIARY DESIGNATION: Full name of beneficiary, relationship to insured, and date of birth for minor children.

Beneficiary: _____ Social Security Number: _____

If beneficiary not living, to: _____ Social Security Number: _____

_____ Social Security Number: _____

SECTION 4: I authorize my employer to deduct from my earnings any premium I am required to pay for the coverage I have selected. I reject my opportunity to enroll in any coverage I have checked "No." I understand that I am the beneficiary for insurance on my family members. This form supersedes all previous forms I have submitted for Public Employees Benefits Board coverage.

Signature of Employee: Please sign printed copy Date: _____

SECTION 5:

Nonsmoker Certification

To qualify for the nonsmoker's discount, you **and** your spouse/domestic partner (if [s]he is covered under Part B Basic or Spouse Supplemental) must **not** have used any tobacco products within the past 12 months.

I certify that I have not smoked cigarettes, cigars, or pipes, or used chewing tobacco or nicorette gum within the past 12 months.

Please Note: ReliaStar Life Insurance Company reserves the right to reduce claims payment if false information is submitted or you fail to notify us that you are no longer eligible for the nonsmoker's discount.

Subscriber's Signature: Please sign printed copy Date: _____

Spouse/Domestic Partner's Signature: Please sign printed copy Date: _____

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

For Agency Use Comments	**For Agency Use** Date sent to carrier:

Suggested Beneficiary Designations

Washington is a community property state. Insureds are urged to obtain legal advice before using beneficiary designations limiting their spouses/domestic partners to less than half the proceeds. Also, reference to a will is not acceptable. Always use the full legal name, for example, "Anna May Smith, wife," not "Mrs. John Smith." You should be sure to check with your attorney and discuss whether to update your beneficiary if your marriage/domestic partnership relationship is dissolved or invalidated. Upon your death, Washington State law prohibits payment of assets to the former spouse except under specific circumstances.

Always show date of birth for minor children.

Personal Beneficiaries

1. If ***one individual*** is to be designated, use the full legal name thus – "Anna May Smith, wife," not "Mrs. John Smith."

2. If ***two individuals*** are to be named, designate as follows: "Anna May Smith, wife, and Dorothy Smith Andrews, daughter, in equal shares, or the survivor."

3. If ***three or more individuals*** are to be named, designate as follows: "Anna May Smith, wife, Dorothy Smith Andrews, daughter, and William Smith, son, or the survivors, in equal shares, or the survivor."

4. If ***one or more secondary beneficiaries*** are to be named, they may be designated individually as follows: "Anna May Smith, wife, if living; otherwise Joseph Smith, father, and Elizabeth Smith, mother, in equal shares, or the survivor;" or

   a. If all ***children of the marriage*** are to be named secondary beneficiaries, designate them collectively rather than individually as follows: "Anna May Smith, wife, if living; otherwise the then-surviving children, if any, born of insured's marriage with said wife, in equal shares." (This designation will include children born later without the necessity of changing the designation.)

   b. If all children of the marriage are to be named secondary beneficiaries ***and a second alternate beneficiary is to be named***, designate as follows: "Anna Smith, wife, if living; otherwise the then-surviving children, if any, born of insured's marriage with said wife, in equal shares, or if said wife is not living and there is no such child, James Smith, father."

   c. If ***children not of the present marriage*** are to be included, designate as follows: "Anna May Smith, wife, if living; otherwise John Smith, born 8-5-86, and Mary Smith, born 2-21-88, children, and any other child or children born of insured's marriage with said wife, or the survivors, in equal shares, or the survivor."

   d. If a ***"Clean Up Fund"*** of a stated amount is desired and there are secondary beneficiaries who are minor, the designation may be as follows: "The proceeds up to $_____ to Anna Smith, wife, if living; otherwise the executors or administrators of the estate of the insured, and the remainder to said wife, if living; otherwise John Smith and Mary Smith, children, in equal shares, or the survivor." Minor children should not be named beneficiaries of proceeds intended for "Clean Up Fund" because the guardian of the children probably could not use the proceeds for the purpose.

Estate

5. If an estate is named, specify whose estate, such as: "Estate of the Insured."

Trustee

6. Trustee under the last will and testament of the insured, or his successors in trust, ***provided, however,*** that if no claim is made by said Trustee within one year from the date of death of the insured or if the insured shall die leaving no last will and testament containing a trust covering this policy, the proceeds shall be payable to the estate of the insured. Payment of the proceeds of this policy to said Trustee or successors in trust shall fully and finally discharge the Company from all liability.

7. "The _____ Trust Company, Trustee under written trust agreement dated _____(month/day/year), or its successor or successors in trust, and payment of the proceeds of this certificate to said Trustee or successor or successors shall fully and finally discharge the Company from all liability."

Business Partners

8. Under a cross ownership plan, designate the surviving partners as beneficiaries. For example, for insurance on the life of John Jones, designate "Henry Smith and William Brown, partners, in equal shares, or the survivor." Similar designation may be made for the other partners.

   Just as a corporation may be the owner and beneficiary of a policy, a partnership may, in the partnership name, own and be the beneficiary of a policy. The firm name should be used together with the words, "a partnership." For example, "Jones, Smith, and Brown, a partnership presently consisting of John Jones, Henry Smith, and William Brown."

Per Stirpes

9. "_____, wife, if living, otherwise the then-surviving children, if any, born of insured's marriage with said wife and the then-surviving legally adopted child or children of the insured, if any, in equal shares, except in case of death of any child or children of said marriage or any legally adopted child or children of the insured, leaving lawful surviving child or children (including legally adopted children but not including grandchildren or other remote descendants), such child or children of the deceased child shall receive, in equal shares, the share which such deceased child would have received if he or she had survived."

Completing the PEBB Life Insurance Enrollment/Change Form

General Directions:

- Please read **all** instructions before you begin.
- Detach at perforation before completing forms.
- Sections 1-5 must be completed by the employee.
- Please type or print all information.
- Shaded areas are to be completed by the agency payroll/personnel/benefits office.
- References to "domestic partner" in this packet **only** include qualified same-sex domestic partners.
- If you are adding a new spouse/domestic partner to your coverage, complete the *Declaration of Marriage/Same-Sex Domestic Partnership* form. Domestic partners must also complete the *Declaration of Tax Status* form. These forms are available from your personnel/payroll office.

SECTION 1

Please provide personal information.

SECTION 2

Please follow down column "2B. Desired Coverage" and mark either "Yes" or "No" for each type of coverage listed–even for coverage that is not being changed.

Note: Public Employees Benefits Board coverage automatically provides $25,000 in Basic Life and $5,000 Accidental Death and Dismemberment (AD&D) benefits for you as a PEBB member.

If you desire optional or supplemental coverage for either yourself or your spouse/domestic partner, enter the dollar amount of coverage
you desire–even for coverage that is not being changed.

Underwriting Approval Requirements

Any coverage requested outside of the initial eligibility period, for either you or your spouse/domestic partner, will require underwriting approval. A separate *Evidence of Insurability Form* (behind this instruction sheet) must be completed and submitted to agency payroll, benefits office, or ReliaStar Life Insurance Co. All underwriting is done through ReliaStar Life Insurance Company.

You may elect the following amounts within your first 60 days of insurance eligibility without submitting the application for underwriting approval. Coverage beyond this amount requires approval.

Guaranteed Issues

Basic Spouse Life/Part B	$2,500
Basic Children Life/Part B*	$2,500
Supplemental Spouse Life/Part B	$25,000
Optional Life/Part C (Employee)	Up to annual salary
Supplemental Life/Part D (Employee)	$50,000

Type of Coverage

Optional Life/Part C: Within the first 60 days of insurance eligibility, you may elect up to your annual salary amount (rounded up to the nearest $1,000) without underwriting approval (see "Underwriting Approval Requirements" above). You may also have this amount automatically increased as your annual salary increases. (Be sure to check box "Yes" for the maximum under "optional life.")

Example:

$2,546		Monthly Salary
x 12		Months
$30,552	=	Annual Salary ⇨ Optional Life/Part C Available $31,000

Supplemental Life/Part D: Within the first 60 days of insurance eligibility, you may elect up to $50,000 coverage without underwriting approval. Additional coverage (up to $350,000 maximum) requires underwriting approval (see "Underwriting Approval Requirements").

Optional AD&D/Part E*: Optional AD&D insurance will pay, in addition to any other insurance you are enrolled in, if death is determined accidental. Please refer to your life insurance booklet for more information.

Spouse/Domestic Partner Insurance Information

Basic Spouse Life/Part B: Within your first 60 days of insurance eligibility or within the first 60 days of marriage/domestic partnership, your spouse/domestic partner may enroll in Basic Spouse Life/Part B without underwriting approval.

Supplemental Spouse Life/Part B: The amount of Supplemental Spouse Life cannot exceed one-half of the amount of Optional Life/Part C and Supplemental Life/Part D coverage selected for you. Within your first 60 days of insurance eligibility, your spouse/domestic partner may enroll for up to $25,000 in Supplemental Spouse Life/Part B without underwriting approval. You must have at least $50,000 in force. Additional coverage requires underwriting approval (see "Underwriting Approval Requirements").

Example:

Employee coverage:	$30,000	Optional Life/Part C
+	$50,000	Supplemental Life/Part D
	$80,000	

Spouse/domestic partner is eligible for up to $40,000 (1/2 of $80,000) Supplemental Spouse Life/Part B insurance.

Premium Rates (Parts B Supplemental, C, & D)

Premium rates are based on your age. A rate chart is listed below.

Cost Per $1,000 Per Month

Employee's age	Nonsmoker	Smoker
less than 25	$0.034	$0.044
25 - 29	$0.036	$0.052
30 - 34	$0.040	$0.070
35 - 39	$0.048	$0.078
40 - 44	$0.076	$0.088
45 - 49	$0.110	$0.130
50 - 54	$0.172	$0.202
55 - 59	$0.320	$0.376
60 - 64	$0.490	$0.578
65 - 69	$0.902	$1.110
70+	$1.348	$1.800

Your premium rate changes to the next higher rate as you reach each new age bracket.

SECTION 3

Please indicate your beneficiary, following the examples on the back of this form.

SECTION 4

Please sign and date the form.

Note to Agencies:

Review for completeness and accuracy, and key guaranteed issues before submitting to ReliaStar Life Insurance Co.

*Never needs approval